Suffolk County Department of Social Services

ALCOHOL/SUBSTANCE ABUSE SCREENING INSTRUMENT

CASE NAME _____ CLIENT NAME _____ CASE NO. _____

CENTER/UNIT _____ WORKER NAME _____ DATE _____

IMPORTANT NOTICE:
This screening instrument will help DSS decide if any further steps are needed to assist you and your family. Depending upon your answers to these questions, the following may occur:

1. **You may be required to be further assessed by a substance abuse counselor.**
2. **You may be required to participate in a treatment program.**
3. **If any evidence is found during these steps that your children are at risk due to your possible substance abuse problems, a referral will be made to Child Protective Services.**

1. In the last 12 months, have you ever felt you ought to cut down on your drinking or drug use? ☐ Yes ☐ No
2. In the last 12 months, have people annoyed you by criticizing your drinking or drug use? ☐ Yes ☐ No
3. In the last 12 months, have you ever felt bad or guilty about your drinking or drug use? ☐ Yes ☐ No
4. In the last 12 months, have you ever felt the need for an "eye opener" or awakened wanting a drink or another drug. ☐ Yes ☐ No
5. In the last 12 months, have you ever been hospitalized because of alcohol or drug use? (Examples: 1. Having been in an accident while drunk or high; 2. Having a severe psychiatric problem like a suicide attempt after or during alcohol or drug use; 3. Having an alcohol or drug overdose.) ☐ Yes ☐ No
6. In the last 12 months, have you lost a job or failed to complete school or a training program due to alcohol or drug use? ☐ Yes ☐ No
7. In the last 12 months, have you lost housing (been evicted or became homeless) due to alcohol or drug use? ☐ Yes ☐ No
8. In the last 12 months, have you ever tried unsuccessfully to stop or greatly reduce your amount of drinking or drug use? ☐ Yes ☐ No
9. In the last 12 months, have you ever been in alcohol/substance abuse treatment? ☐ Yes ☐ No

Client Signature: _____ Date: _____

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FOR DSS USE ONLY
CLIENT REFERRED FOR ALCOHOL/SUBSTANCE ABUSE ASSESSMENT? ☐ Yes ☐ No
COMMENTS: _____
_____
_____

Distribution: Original to case record. If referral indicated: copy to clinic and Center Manager